YOUTH SUICIDE

Introduction

Suicide and suicide attempts by children and adolescents constitute a major public health problem in the United States. Each year in the United States, thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15 to 24 year-olds, and the sixth leading cause of death for 5 to 14 year-olds (American Academy of Child & Adolescent Psychiatry [AACAP], 2004). Moreover, the middle teenage years are the period in the life cycle where the incidence of suicide attempts is the greatest (Fritz, 2001).

According to Garland and Zigler, as cited by the Virginia Commission on Youth (2001), the adolescent suicide rate increased 200% over the last three decades, compared with a 17% increase in the general population. In 1998, an average of one young person every two hours took his or her own life (National Center for Health Statistics, as cited by the Virginia Commission on Youth). Furthermore, the actual number of deaths caused by suicide is likely to be higher because some deaths may have been classified as accidental. Chart 1 shows the suicide rates for persons in the U.S. ages 10 to 24 between 1991 and 2004.

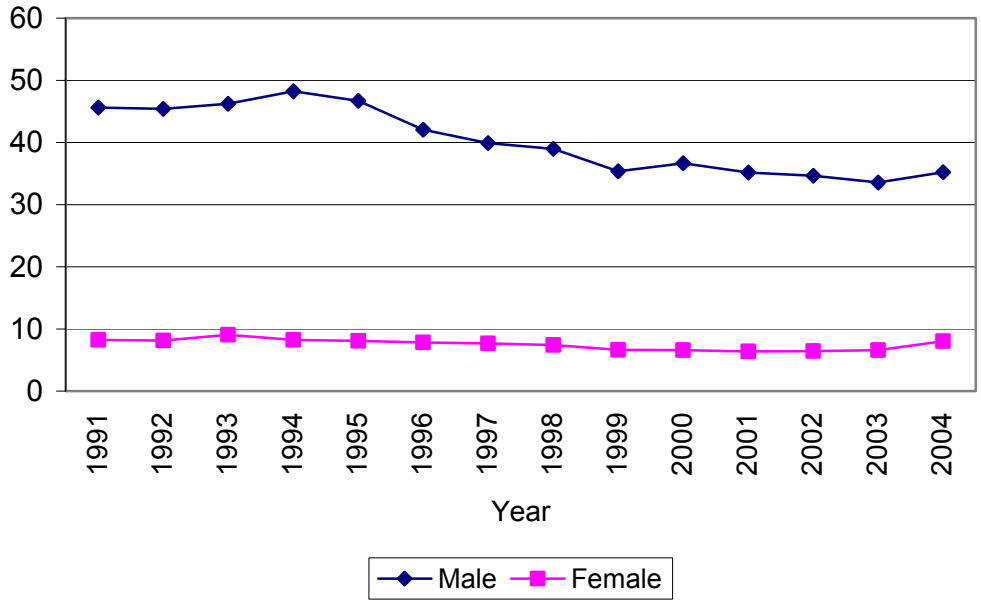
In 2007, the U.S. Centers for Disease Control and Prevention (CDC) reported the largest one-year increase in youth suicide rate in 15 years (Centers for Disease Control and Prevention, Suicide Trends among Youths and Young Adults, 2007). According to the CDC report, there are three gender-age groups—10 to 14 year-old females, 15 to 19 year-old females, and 15 to 19 year-old males—which account for the overall increase in suicide rates for youth. The report includes the following statistics for increased suicide rates among youth from 2003 to 2004:

- For 10 to 14 year-old females, the rate increased from 0.54 to 0.95 per 100,000;
- For 15 to 19 year-old females, the rate increased from 2.66 to 3.52 per 100,000; and
- For 15 to 19 year-old males, the rate increased from 11.61 to 12.65 per 100,000.

The CDC also reported a change in the methods used to attempt suicide. Firearms were the most common method for both females and males in 1990. However, in 2004, hanging/suffocation was the most common method of suicide for females, resulting in 71% of suicides among girls aged 10 to 14 and 49% among both males and females ages 15 to 19 (CDC, 2007). Although the use of firearms has changed for females, firearms remain the most common method of suicide for males (CDC).

Chart 1

U.S Suicide Rates* for Persons 10-24 Years of Age



*Per 100,000 persons

Source: Commission on Youth Analysis of Centers for Disease Control and Prevention Data, 2007.

There has been increasing attention paid to the issues of suicide and suicide prevention and, in 1999, the U.S. Surgeon General issued a "Call to Action" emphasizing the need for greater awareness off this national problem (U.S. Department of Health and Human Resources, 2001). Shortly thereafter, the *National Strategy for Suicide Prevention* was published by the U.S. Department of Health and Human Services, addressing issues such as collaboration with agencies and stakeholders (Vetter, 2002).

Table 1 sets forth Virginia's suicide statistics.

Table 1

Virginia Suicide Statistics

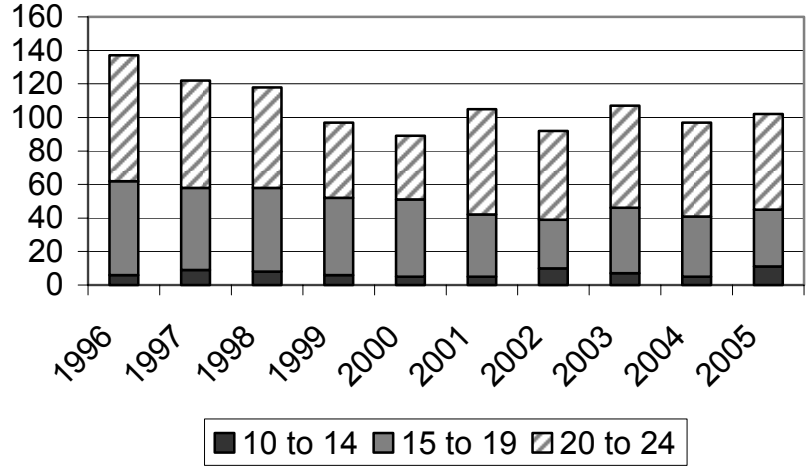
In Virginia, suicide is:
- the third leading cause of death for ages 10-24,
- the second leading cause of death for ages 25-34, and
- the fourth leading cause of death for ages 35-54.
- In almost all age groups, Virginia's suicide rates are slightly higher than the national average.
- One teenager a week, two adults each day, and one older adult every 3 days are lost to suicide.
- There are an estimated 25 suicide attempts for every death by suicide.
- In 2000, the total cost for hospitalizations due to suicide attempts in Virginia was over $25 million.

Source: Vetter, 2002.

In Virginia, five suicides were reported in the 10 to 14 age group in 2004, resulting in a 1.0 suicide rate. In that same period, 38 suicides were reported in the 15 to 19 age group, resulting in a 7.3 suicide rate (Virginia Department of Health, Office of the Chief Medical Examiner, 2006). Chart 2 outlines Virginia deaths from suicides from 1996 to 2005.

Chart 2

Virginia Deaths from Suicides 1996-2005
Ages 10-24



Source: Virginia Department of Health, Division of Injury and Violence Prevention, 2007.

Contributing Factors in the Rise of Youth Suicide

According to NAMI, suicide is the result of many complex factors (2004). More than 90% of youth suicide victims have at least one major psychiatric disorder (Gould et al., as cited by NAMI, 2004). Hopelessness appears to be an important mediating variable between depression and suicide (Gould et al., 2004). Anxiety, particularly when it co-occurs with depression, also increases the risk of suicide (Gould et al.).

Several factors contribute to a child or adolescent attempting or completing suicide. The American Academy of Pediatrics, as cited by the Virginia Commission on Youth (2001), identifies a number of factors, which may explain the increase in youth suicide in recent years:

- Ease in obtaining the tools for suicide;
- The pressures of modern life are greater;
- Competition for good grades and college admission is stiff;
- More violence is seen in the media; and
- Parents may be less involved in their children's lives.

Warning signs for suicide are evidenced in changes in a person's normal behavior and may include loss of interest in activities once thought of as pleasurable, giving away possessions of personal value, substance abuse, change in weight, apathy about appearance, personality changes and an increase in self-harming behaviors (Better Health Channel, 2000).

Other important risk factors for suicide and suicidal behavior, according to NAMI (2004), include:

- Prior suicide attempt;
- Co-occurring mental and alcohol or substance abuse disorders;
- Family history of suicide;
- Parental psychopathology;
- Hopelessness;
- Impulsive and/or aggressive tendencies;
- Easy access to lethal methods, especially guns;
- Exposure to the suicide of a family member, friend, or other significant person;
- History of physical or sexual abuse;
- Same-sex sexual orientation (shown only for suicidal behavior, not suicide);
- Impaired parent-child relationships;
- Life stressors, especially interpersonal losses and legal or disciplinary problems; and
- Lack of involvement in school and/or work ("drifting").

If adolescents are currently receiving psychiatric treatment for a mental health disorder, these risk factors can be discussed with the family and the treatment team so that the adolescent can be appropriately monitored.

Table 2 presents statistics addressing risk factors for youth suicide.

Table 2

Facts about Youth Suicide

- Suicide is much more common in adolescent and young adult males than females.
- The ratio for male to female suicides is 3:1 in the rare prepubescent suicides to approximately 5.5:1 in 15 to 24 year-olds.
- Mood disorders, poor parent communication, and a previous suicide attempt are risk factors for suicide in both boys and girls.
- Previous suicide attempts are more predictive in male.
- Substance and/or alcohol abuse significantly increases the risk of suicide in teenagers aged 16 and older.
- Family pathology and a history of family suicidal behavior may also increase risk and should be investigated.

Source: American Academy of Pediatrics, as cited by the Virginia Commission on Youth, 2001.

Research reveals that youth suicide is neither random nor inevitable. The Virginia Commission on Youth, in its study report on youth suicide (2001), suggested that, in order to address youth suicide, one must also be made aware of the dynamics surrounding this issue. In its report, *Suicide Fatalities among Children and Adolescents in Virginia 1994-95*, the Virginia State Child Fatality Review Team found that more than 40% of the youth who took their lives had told someone about their intent to die (Virginia Commission on Youth). Unfortunately, for various reasons, the opportunities to intercede were lost. Also discussed in the report were the significant findings that the warning signs for youth suicide were not recognized, the extent of the problem was not understood, the means for conducting the act were not removed, and families often thought they could handle the problems themselves. Contributing to the problem was that families may not have known where or how to get help or that help, in fact, was not available.

There has been considerable debate about the use of antidepressants in treating youth and about whether their use increases the risk of suicidal behaviors. A further description of the use of antidepressants is included in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Mental Health Disorders and Youth Suicide

The factors that predispose children and adolescents to complete suicide are numerous. The American Academy of Child & Adolescent Psychiatry's (AACAP) *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior* (2000) discusses the importance of understanding the various risk factors for potential suicidal behavior. The following elements are discussed in the following paragraphs.

> One such risk factor that may indicate potential suicidal behavior is pre-existing psychiatric disorders. More than 90% of adolescents who commit suicide suffered from an associated psychiatric disorder at the time of their deaths. More than half had suffered from a psychiatric disorder for at least two years preceding the event.
>
> Another potential risk factor is the presence of disruptive disorders. Disruptive disorders increase the risk of suicidal thoughts in children 12 years old and younger. Moreover, substance use or separation anxiety may incite adolescents to attempt suicide. Mood and anxiety disorders increase the risk of suicidal ideation in children and adolescents. Panic attacks are a risk factor for both ideation and attempts in females, while aggressiveness increases the risk of suicidal ideation or attempt in males.

As indicated in a Joint Statement of the AACAP (2001) and the American Psychiatric Association, some of the behavioral health issues in adolescents associated with suicidal thoughts or behaviors include depression, ADHD, and bipolar disorder (2001). Depression has been identified as the top risk factor in youth suicide, with estimates of five percent of children and adolescents in the general population being depressed at any point in time. Children at a higher risk for depression are those under stress, those experiencing loss, and those with attention, learning, conduct or anxiety disorders. In addition, studies disclose that teenagers with bipolar disorder may have an ongoing combination of moods, which may increase the risk.

Adolescents with a combination of mood disorders and disruptive behaviors are also at a significantly increased risk of suicide (Basco, 2006). Data from the 1999 National Youth Risk Behavior Survey showed that 17% of teens surveyed demonstrated at least three problem behaviors; this group comprised 60% of those who attempted suicide (Basco). Stress events often precede adolescents' suicides; however, it is difficult to discern whether the stress is a result of the mental disorder or is related to events with which the child or adolescent having a mental disorder is unable to cope (AACAP, 2000). Furthermore, an adolescent with a mental disorder may be faced with a greater number of stressful events and may perceive the events that occur as more stressful than an adolescent who does not have a diagnosed mental disorder (AACAP).

A recent study has shown that many adolescents who report having suicidal thoughts or behaviors are not recognized by school officials to be at risk (Moyer, 2004). One study found that 35% of youth suicides occurred the same day youth experienced a crisis such as a relationship breakup or an argument with a parent (Suicide Prevention Resource Center, as cited by the Virginia Department of Health, 2006). Identifying these students would help to diagnose potential mood disorders and treat symptoms sooner, before any serious suicide attempts occurred (Moyer).

Even the most capably trained clinician can find it difficult to differentiate between those youth who have thoughts of engaging in suicide and those intending to commit the act of suicide. Many adolescents who have made a medically serious attempt will never do so again, while others who have made what seemed like only a mild attempt may eventually commit suicide (American Academy of Child & Adolescent Psychiatry and American Psychiatric Association, 2001). However, research has provided some broad indicators about risk factors and means for assessing the risk.

Virginia's Suicide Prevention Plan

Senate Joint Resolution 148, introduced in the 2000 General Assembly, directed the Commission on Youth, with the assistance of the Departments of Health, Education, and Mental Health, Mental Retardation and Substance Abuse Services, to develop a comprehensive youth suicide prevention plan. With the support of the departments identified above and significant input from survivors, service providers, and other stakeholders, the Commission undertook development of the plan.

The goals of the Virginia Youth Suicide Prevention Plan, as presented by the Virginia Commission on Youth (2001), were:

- To prevent suicidal behavior among youth in Virginia;
- To reduce the impact of suicide and suicidal behavior on individuals, families, and communities; and
- To improve access to and availability of appropriate prevention services for vulnerable individuals and groups.

The Commission on Youth conducted an extensive review of the research and, in the Suicide Prevention Plan, discussed the evidence for effectiveness of various youth suicide prevention strategies in place around the country. General recommendations were made, based on research compiled by the U.S. Centers for Disease Control and Prevention, as cited by the Virginia Commission on Youth (2001):

- Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources in the community.
- Avoid reliance on one prevention strategy.
- Incorporate promising but underused strategies into current programs where possible.
- Expand prevention efforts for young adults, aged 20-24 years of age.
- Incorporate evaluation efforts into all new and existing suicide prevention programs.

Universal prevention strategies were recommended as part of Virginia's Youth Suicide Prevention Plan. The Commission on Youth model for Virginia's Youth Suicide Prevention Plan was adapted from the model developed by the Institute of Medicine and the National Institutes of Health. The prevention scheme included three levels of prevention strategies: universal, selective, and indicated.

Universal prevention is the provision of needed interventions to keep communities healthy. These programs provide general awareness information and education. The most effective programs integrate suicide prevention into a competence-promotion and stress-protection frameworks (Virginia Office of the Secretary of Health and Human Resources, 2004).

The mission of selective prevention is to prevent the onset of suicidal behavior in targeted risk groups. These strategies include screening and assessment, training of "gatekeepers," and community-based mental health treatment. Early treatment for child abuse victims, as well as early family-based interventions to reduce child abuse, can be expected to reduce suicide since childhood sexual abuse is a risk factor in 9 to 20% of suicide attempts (Virginia Office of the Secretary of Health and Human Resources, 2004). Effective screening and treatment can potentially prevent incidents of suicide attempts.

Indicated prevention strategies target individual youth known to be at high risk for suicide in order to provide skill building and supportive services and treatment. Family support training, case management, and skill building for high-risk youth have been found to be successful in reducing depression, hopelessness, and suicidal behaviors (Virginia Office of the Secretary of Health and Human Resources, 2004).

Upon the recommendation of the Virginia Commission on Youth, the 2001 General Assembly enacted legislation which designated the Virginia Department of Health as the lead agency for directing youth suicide prevention activities across the Commonwealth. The Department of Health was charged with coordinating the activities of agencies pertaining to youth suicide prevention to address various preventive and support issues. Currently, the Department of Heath and the Virginia Department of Mental Health Mental Retardation and Substance Abuse Services actively participate in the Virginia Suicide Prevention Council, a public-private partnership designed to concentrate on suicide prevention in the Commonwealth. These activities assist with education and the implementation of prevention practices found to be crucial in reducing youth suicide. Under the leadership of the Virginia Department of Health, over 100,000 Virginians have been trained to identify the warning signs of suicide in others and to know the proper procedures for getting help for a person in distress.

Evidence-based Practices in Youth Suicide Prevention

As interventions for preventing suicide are developed and implemented, several key factors must be considered. It is critical that youth with psychiatric disorders or otherwise at increased suicidal risk receive adequate assessment, treatment, and follow-up care (U.S. Department of Health and Human Services, 2001).

The following finding emerged from information reported by the U.S. Department of Health and Human Services (2001):

> Clinical studies have shown the efficacy of training emergency department staff to treat suicide attempts with gravity and to emphasize to family members the dangers of ignoring suicide attempts. Furthermore, the benefits of follow-up treatment to reduce the recurrence of attempted suicide should be emphasized. Such training has been linked to greater completion of treatment on the part of persons having sought care in emergency departments.

According to the American Academy of Child & Adolescent Psychiatry (AACAP) and American Psychiatric Association (APA) (2001), clinicians should be prepared to admit suicide attempters who express a persistent wish to die or are exhibiting symptoms of severe mental disorders. Discharging the youth should occur only after the following three issues have been addressed. These include: making certain adequate supervision is available; ensuring that the level of suicidality has stabilized; and gaining assurance that the youth's environment will be rid of all

potentially-lethal items, such as guns or medications. Following up with appropriate psychotherapy is vital in order to appropriately treat the mental disorders associated with suicidal behavior. Additionally, psychotherapy must be tailored to meet the needs of the youth appropriately and to treat any diagnosed mental disorders effectively.

Coping behaviors developed during adolescence may be precursors of patterns of coping through adulthood, so it is imperative that service providers and researchers understand the range and associated coping behaviors that adolescents may establish (Gould et al., 2004). Thus, cognitive behavioral approaches may provide a method to assess coping strategies and beliefs that may be associated with maladaptive beliefs (Gould et al.). This is based on study findings indicating that adolescents who are at risk of suicidal behavior are less likely to employ appropriate coping strategies (Gould et al.). Gould asserts that high-risk adolescents may possess beliefs that support the use of maladaptive coping strategies (such as substance use) to deal with depression and suicidal thoughts and behaviors.

Pharmacological Treatment

U.S. Department of Health and Human Services (2001) has outlined pharmacological interventions thought to be effective in reducing suicide. However, it must be emphasized that any medications prescribed to the suicidal child or adolescent must be carefully monitored by a third party and any change of behavior or side effects immediately reported. New interventions are being developed and tested for the treatment of disorders associated with suicidal behaviors. Because few studies of treatments for mental disorders have included suicidal individuals, treatments need to be assessed for their potential to reduce suicide and suicidal behaviors. Furthermore, the youth must be thoroughly assessed for any mental disorders, and psychopharmacological interventions must be tailored to address any diagnosed disorders.

To date, there are only two psychopharmacological treatments associated with reduced suicide—lithium and clozapine (Baldessarini et al., as cited by the U.S. Department of Health and Human Services, 1999). Research into lithium, which is shown to have a significant impact on the reduction in the suicide rate, is extensive.

According to the AACAP and the American Psychiatric Association (2001), selective serotonin reuptake inhibitors (SSRIs) may be successful in reducing suicidal ideation and suicide attempts in non-depressed adults with certain personality disorders. However, it is necessary to closely monitor children and adolescents on SSRIs to insure that no new suicidal ideations are noted.

Antidepressants and the Risk of Suicidal Behavior

The information discussed below is attributed Gould et al. (2004). There has been considerable debate about the use of antidepressants in treating children and adolescents with depression and whether SSRIs increase the risk of suicidal behaviors in these youth. Some researchers assert that increased prescriptions of SSRIs have resulted in decreased suicide rates. However, findings from randomized controlled trials reveal that certain medications are contraindicated for youth under 18 years of age. As directed by the Food and Drug Administration in September of 2004, manufacturers in the United States are now required to place a “black box” warning label on these medications.

A more detailed discussion regarding the use of antidepressants in treating children and adolescents is included in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Contraindicated Treatments

As noted by the AACAP and the American Psychiatric Association (2001), tricyclic antidepressants should not be prescribed for the suicidal youth as a first line of treatment because the potential for toxic effect outweighs the therapeutic effects. Studies have not found these drugs to be effective in reducing suicide in children or adolescents. Furthermore, other medications that may increase disinhibition or impulsivity, such as the benzodiazapines and Phenobarbitol, should be prescribed with caution.

Cultural Considerations

The following is taken from a synopsis of proceedings of a NIMH conference held in 2004 at the Annenberg School for Communications and Inn at the University of Pennsylvania.

> According to the Centers for Disease Control and Prevention, valid measurement of suicidality for many cultures remains a critical need. Research with populations who are culturally and linguistically diverse raises a number of issues including variation in concepts and language for suicide, measurement correspondence, and communication of internal processes related to suicide concepts. This includes how emotional and cognitive states are communicated and addresses the variations that exist in language usage. Cultural relevance must be addressed in both concept and intervention (e.g., the role of family, religious traditions, and values or rituals).

The rate of suicide among African American youth has declined from 11.48 to 7.22% from 1994 to 2004, resulting in a 59% decrease (American Association of Suicidology, 2007). In addition, suicide in African American males was 5.6 times higher than suicide in African American females (American Association of Suicidology).

According to *Health, United States, 2004*, as reported by the Technical Assistance Partnership for Child and Family Mental Health, adolescent Hispanic females are significantly more likely than adolescent Hispanic males to consider suicide, attempt suicide, and injure themselves in attempting suicide. The rate of suicide attempts among female Hispanic youth also exceeds that for their African American and Caucasian female counterparts. For example, Hispanic female students in grades 9 through 12 have a greater percentage of suicide attempts, at 14.9%, which is greater than the reported attempts of their Caucasian, non-Hispanic counterparts, at 9.3%, and African American counterparts, at 9.8% (Eaton et al., 2006 as cited by Centers for Disease Control and Prevention, *Facts at a Glance*, 2007). This disparity has been attributed to sex role socialization, acculturation, social and linguistic isolation, and depression.

Youth who engage in suicidal behavior vary considerably with respect to specific forms of risk factors. Barriers to treatment may exist due to differences in language, the degree of alienation and isolation that may be present, and other existing cultural stressors (Barnes, 2004). It is evident that these risk factors can be lethal; sustained attention to the problems evidenced by this vulnerable population is needed across the lifespan.

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Organizations/Weblinks

American Association for Suicidology
1-800-273-TALK (8255)
http://www.suicidology.org

American Foundation for Suicide Prevention
http://www.afsp.org

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
1-800-CDC-INFO
www.cdc.gov/injury

Central Shenandoah Youth Suicide Prevention
www.preventsuicidecsv.org

Crisis Line of Central Virginia
www.crisislineofcentralvirginia.org

The Children's Safety Network
http://www.childrenssafetynetwork.org

Florida Initiative for Suicide Prevention
http://www.fisponline.org

Jason Foundation
http://www.jasonfoundation.com

The Link's National Resource Center for Suicide Prevention
http://www.thelink.org

National Hopeline Network and the Kristin Brooks Hope Center
800-SUICIDE 784-2433
http://www.hopeline.com

N**ational Organization for People of Color against Suicide (NOPCAS)**
P.O. Box 75571 - Washington, DC 20013
202-549-6039 - Fax/Voicemail: 1-866-899-5317

National Suicide Prevention Resource Center
1-800-273-TALK (8255)
http://www.sprc.org

National Youth Violence Prevention Resource Center
http://www.safeyouth.org

National Alliance for the Mentally Ill (NAMI)
http://www.nami.org

Organization of Attempters and Survivors of Suicide in Interfaith Service (OASSIS)
http://www.oassis.org

Prevent Suicide Virginia
www.preventsuicideva.org

Suicide Awareness Voices of Education
http://www.save.org

Suicide Prevention Advocacy Network USA, Inc. (SPAN)
http://www.spanusa.org

U.S. Department of Health and Human Services
National Strategy for Suicide Prevention
http://www.mentalhealth.org/suicideprevention/strategy.asp

Virginia Department of Health Center for Injury and Violence Prevention
Calvin Nunnally, Suicide and Youth Violence Prevention Consultant
P.O. Box 2448, 109 Governor Street - Richmond, VA 23219
804-864-7736 - Fax 804-864-7748
calvin.nunnally@vdh.virginia.gov
http://www.vahealth.org/civp/preventsuicideva/index.asp

Youth Suicide Prevention Program (YSPP)
http://www.yspp.org

National Suicide Hotlines

Toll-Free / 24 hours / 7 days a week

National Hopeline Network
1-800-SUICIDE
1-800-784-2433

National Suicide Prevention Lifeline
1-800-273-TALK
1-800-273-8255

http://suicidehotlines.com/national.html

TTY: 1-800-799-4TTY (4889)

Crisis Centers in Virginia Localities

Information is provided by the Virginia Department of Health's Suicide and Youth Violence Prevention Program and local providers.

November 2007

Arlington
CrisisLink
703-527-4077 (TTD Accessible)

Blacksburg
Access Emergency and Emergency Services
540-961-8400

Charles City County
804-261-8484
804-966-2496

Chesterfield County
804-748-6356

Clarke
540-667-0145

Dumfries
703-368-4141
Teen line 703-368-8069
Spanish 703-368-6544 (6:00 p.m.-10:00 p.m. M-F)

Frederick
540-667-0145

Goochland County
804-556-3716

Hampton
757-380-9024

Hanover County
804-752-4200

Henrico Mental Health
804-261-8484
804-966-2496

Lynchburg
Crisis Line of Central VA
888-947-9747 or 804-947-4357
Teen talk 888-299-7277

Martinsville
Contact for Martinsville/Henry County
540-489-5490 - Franklin

Middle Peninsula
804-758-9398

New Kent County
804-261-8484
804-966-2496

Norfolk
757-622-1126

Northern Neck
800--542-2673 (COPE)
804-693-2673

Powhatan County
804-598-2697

Richmond
804-819-4100

Roanoke & New River Valley
540-961-8400

Shenandoah County
540-459-4742

Warren County
540-635-4357

Winchester
540-667-0145